Maryland Department of Health and Mental Hygiene

Vital Statistics Administration

Maryland Facility Worksheet for the Certificate of Live Birth

To be completed by Facility Staff

- For pregnancies resulting in the birth of two or more live-born infants, this worksheet should be completed for the 1st live born infant in the delivery. For each subsequent live-born infant, complete the Attachment for Multiple Births.
- For detailed definitions, instructions, information on sources, and common key words and abbreviations, see the Guide to Completing Facility Worksheets for the Certificate of Live Birth.
- For any fetal loss in the pregnancy reportable under State reporting requirements, complete and file the Certificate of Fetal Death.

Mother's Name: _____ **Mother's Record #** _____

Child's Name: _____ **Child's Record #** _____

Child Number: _____ **of** _____ **total deliveries (living or stillborn) resulting from this pregnancy**

Child's Sex: ❑ Male ❑ Female ❑ Not Yet Determined **Child's Date of Birth:** _____ _____ 20 _____
Month Day Year

Child Being Placed for Adoption? ❑ Yes

Signature of Person Completing Facility Worksheet: _____

SCREEN: FACILITY

6. Did mother receive prenatal care?
❑ Yes ❑ No → If NO, go to #8

6a. Date of first prenatal care visit
____ /____ / 20____
Month Day Year

6b. Date of last prenatal care visit
____ /____ / 20____
Month Day Year

7. Total number of prenatal care visits
_____

8. Date last normal menses began
____ /____ / 20____
Month Day Year

9. Number of previous live births now living—Don't include this child.
_____ ❑ None

10. Number of previous live births now dead—Don't include this child.
_____ ❑ None

11. Date of last live birth
____ /_____
Month Year

12. Total number of other pregnancy outcomes—Include fetal losses of any gestational age– including spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy.
_____ ❑ None

13. Date of last other pregnancy outcome
____ /_____
Month Year

14. Risk factors in this pregnancy *Mark (✕) all that apply.*
- ❑ Diabetes (Prepregnancy)
- ❑ Diabetes (Gestational)
- ❑ Hypertension (Prepregnancy)
- ❑ Hypertension (Gestational)
- ❑ Eclampsia
- ❑ Previous preterm births
- ❑ Other previous poor outcome
- ❑ Previous cesarean delivery
  Number _____
- ❑ None of the above

15. Infections present/treated during pregnancy *Mark (✕) all that apply.*
- ❑ Gonorrhea
- ❑ Syphilis
- ❑ Chlamydia
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ None of the above

16. Obstetric procedures *Mark (✕) all that apply.*
- ❑ Cervical cerclage
- ❑ Tocolysis
- ❑ External cephalic version SUCCESSFUL
- ❑ External cephalic version FAILED
- ❑ None of the above

SCREEN: LABOR/DELIVERY

17. Onset of Labor *Mark (✕) all that apply.*
- ❑ Premature rupture of membranes (≥12 hrs)
- ❑ Precipitous labor (< 3 hours)
- ❑ Prolonged labor (≥20 hrs)
- ❑ None of the above

19. Time of birth
_____ :_____ 24 hour clock

20. Certifier's name

_____

FIRST Name MIDDLE Name(s) LAST Name Suffix

Certifier's title ❑ M.D. ❑ D.O. ❑ Hospital Administrator
❑ CNM/CM ❑Other Midwife ❑Other _____

21. Date record certified

____ /____ / 20____
Month Day Year

22. Principal source of payment for delivery?

❑ Private Insurance ❑ Self-pay ❑ Medicaid
❑ Other *(Specify)* _____

24. Was mother transferred to this facility for delivery?

❑ Yes, transferred from: _____ ❑ No

25. Attendant's name

_____

FIRST Name MIDDLE Name(s) LAST Name Suffix

Attendant's title

❑ M.D. ❑ D.O. ❑ CNM/CM ❑ Other Midwife
❑ Other *(Specify)* _____ **Attendant's NPI** _____

26. Mother's weight at delivery

_____ (pounds)

27. Characteristics of labor and delivery *Mark (✕) all that apply.*

❑ Induction of labor
❑ Augmentation of labor
❑ Steroids-fetal lung maturation
❑ Antibiotics-mother during labor
❑ Chorioamnionitis
❑ Mod/heavy meconium staining
❑ Fetal intolerance of labor
❑ Epidural/spinal anesthesia
❑ None of the above

28. Method of delivery *(Complete A and B)*

(A) Fetal presentation at birth *Mark (✕) one.*

❑ Cephalic ❑ Breech ❑ Other

(B) Final route and method of delivery *Mark (✕) one.*

❑ Vaginal/Spontaneous ❑ Vaginal/Forceps ❑ Vaginal/Vacuum
❑ Cesarean → trial of labor attempted? ❑ Yes ❑ No

29. Maternal morbidity *Mark (✕) all that apply.*

❑ Maternal transfusion
❑ Perineal laceration (3° or 4° laceration)
❑ Ruptured uterus
❑ Unplanned hysterectomy
❑ Admission to intensive care unit
❑ Unplanned OR procedure following delivery
❑ None of the above

SCREEN: NEWBORN

30. Birthweight—If weight in GRAMS is not available, indicate LB/OZ. Do not convert lb/oz to grams.

Grams: _____ **OR** Pounds: _____ lb _____ oz

31. Obstetric estimate of gestation—Completed weeks.

_____

33. Apgar score

5 minutes _____ if < 6, Score 10 minutes _____

34. Plurality—Include all live births and fetal losses resulting from this pregnancy.

_____ live births and fetal losses

35. If NOT single birth, order delivered in the pregnancy—Include all live births and fetal losses resulting from this pregnancy.

_____ birth order delivered in pregnancy

36. If NOT single birth—Specify number of infants in this delivery born ALIVE.

_____ infants born ALIVE

37. Abnormal conditions of the newborn—Disorders or significant morbidity. *Mark (✕) all that apply.*

❑ Assisted ventilation required immediately following delivery
❑ Assisted ventilation required for more than 6 hours
❑ NICU admission
❑ Newborn given surfactant replacement therapy
❑ Antibiotics received by newborn for suspected neonatal sepsis
❑ Seizure or serious neurologic dysfunction
❑ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage requiring intervention)
❑ None of the above

38. Congenital anomalies of the newborn *Mark (✕) all that apply.*

❑ Anencephaly
❑ Meningomyelocele/Spina bifida
❑ Cyanotic congenital heart disease
❑ Congenital diaphragmatic hernia
❑ Omphalocele
❑ Gastroschisis
❑ Limb reduction
❑ Cleft lip with/without cleft palate
❑ Cleft Palate alone
❑ Down Syndrome - (Trisomy 21)
  ❑ Karyotype confirmed
  ❑ Karyotype pending
❑ Suspected chromosomal disorder
  ❑ Karyotype confirmed
  ❑ Karyotype pending
❑ Hypospadias
❑ None of the above

39. Was infant transferred within 24 hours of delivery?

❑ Yes, transferred to: _____ ❑ No

40. Is infant living at time of this report?

❑ Yes ❑ No ❑ Infant transferred, status unknown

41. Is infant being breastfed at time of discharge?

❑ Yes ❑ No